Most drug treatment in the United States is based on the “disease model” which views addiction as a primary disease characterized by loss of control and denial and only treatable by abstinence (Denning and Little, 2001; Leshner, 1997; Sill-Holeman, 1999). Programs based on this model generally require abstinence (or the desire to stop using) and terminate clients who relapse. As a result, the many users who are not ready or able to completely give up their drug usage often are left without any services.

Harm Reduction as an Alternative Approach

Harm reduction (HR) offers an alternative to this approach. Initially used in the United States to prevent HIV infection among intravenous drug users, HR has emerged as a strategy for removing barriers (e.g., lack of child-care) and eliminating requirements (e.g., abstinence) to access treatment services. It is a means of “conceptualizing and designing treatment that reaches vulnerable populations… so that people who are unsure of what to do about their drug and alcohol use, or who have complicating factors… can have access to treatment.” (Denning and Little, 2001). The most basic principle of HR is to meet people “where they are at” in order to reduce harm to themselves, their families and their community. “Proponents of HR see [abstinence and using drugs more safely] as consistent strategies with the common goal of helping drug users reach and maintain physical and emotional health, regardless of where they are on the abuse-to-abstinence continuum” (Sorge, 1991).

While it is clear that any use of some substances (e.g., crack cocaine) can be dangerous and is illegal, and that abstinence may be the wisest option for some addicts, HR views reduction in use as a healthy step toward abstinence. In fact, despite the common myth that HR enables drug use, this strategy often involves reducing or eliminating drug use. However, a primary difference between harm reduction and traditional treatment models is that HR approaches measure success by reduction in consequences, rather than (or in addition to) reduction in prevalence of use (Tapert et. al, 1998).

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**Uses of Harm Reduction**

The most widely recognized application of the HR philosophy is needle exchange, which is designed to prevent HIV infection and other health problems among injection drug users. Similarly, methadone maintenance was devised as a way of reducing the harm—to the individual (e.g., overdose and infection) and to society (e.g., crime and cost)—inherent in the use of heroin by injection. While these programs receive some acceptance nationally, use of harm reduction strategies with pregnant and parenting women still raises questions among some treatment and child welfare professionals in the United States.

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**USE OF HARM REDUCTION WITH DRUG USING PARENTS**

There is a growing advocacy movement around the use of harm reduction strategies with drug using women who are pregnant. However, there is relatively little knowledge about the use of harm reduction with parents who use drugs. Whereas few would disagree with the fact that active substance use (whether licit or illicit) can impede one’s ability to parent a child, there is little agreement about how much substance use is too much and whether or not drug use alone is sufficient justification to remove a child from his/her parents. Although there is some evidence about the effect of parental drug use on fetuses and young children (see Kershnan and Tyler articles in this issue), it is unclear how much of the harm is due to substance abuse as opposed to other factors (e.g., poverty). At the same time, there is a growing body of literature illustrating the traumatic impact of separating young children from their parents. Furthermore, the reality is that there are not enough treatment programs to accommodate all the parenting addicts in this country, there are not enough foster or adoptive parents to care for all the children of drug users, and the quality of some of these services and placements are questionable. In developing policies and programs to address these issues, two core questions to consider are: (1) Does an addicted parent have to be abstinent in order to adequately care for her children; and (2) Should an addicted parent have to be abstinent in order to receive services (e.g., drug treatment, mental health, shelter, food) for him/herself or family?

Harm reduction proponents argue that there should be a continuum of comprehensive services for pregnant and parenting drug users that focuses on increasing the safety and well-being of addicts and their children, and a variety of treatment and therapeutic modalities to serve any individual who walks in the door (Thomas, 1999). HR practice recognizes that an addict has the ability to make rational choices about his/her drug use, and that not all addicts are ready, willing or able to participate in treatment at any given time. Therefore, harm reduction strategies emphasize education to help individuals make informed decisions.

Additionally, harm reduction psychotherapists use the “Decisional Balance” to help clients explore their feelings about drug use and behavior change (Denning and Little, 2001). When applied practically, this tool can be used to help addicts compare the pros and cons of changing their behavior to the pros and cons of maintaining their current lifestyle, and explore the relative importance of each item. For example, the possibility of losing one’s child to Child Protective Services may outweigh the benefits one derives from drug use and be enough for that individual to seek drug treatment and make radical life changes; whereas another individual may feel overwhelmed by child-rearing and the prospect of stopping drug use. Interventions for this latter individual may include strategies to relieve the stress of child-rearing (e.g., respite) or information about voluntary relinquishment of parental rights.

Another technique at the core of harm reduction is Substance Use Management (SUM), which “refers to any effort to manage one’s drug use to increase safety, control or to decrease negative consequences of drug use.” (Denning and Little, 2001). In addition to the potential safety benefits to the family, this technique is “useful in information gathering to determine the extent to which a client will be able to manage his use of drugs…” (Denning and Little, 2001). Other HR techniques, many of which are, or could be, incorporated into traditional treatment programs, include: devising safety plans for children when parents use drugs, stress reduction, improving coping skills, nutrition education, relapse prevention, and family therapy.

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**Summary**

Overall, harm reduction aims to reduce “any harm from any high-risk behavior” whether or not it is directly related to substance use (Thomas, 1999). To this end, HR strategies look at increasing the emotional, spiritual, physical and mental well-being of all women...; increasing the safety of women and children...; and increasing access to resources and overall...
self-esteem, self-actualization, and self-mastery." (Thomas, 1999). While these goals are consistent with traditional treatment programs, the strategies, methods, and philosophies may differ considerably. Most notably, for instance, is a belief among harm reductionists that major changes in life functioning and improved parental functioning are possible even if abstinence is not. To this end, rather than focusing on the drug use itself, harm reduction strategies focus on reducing the harms and risks associated with drug abuse, which often leads to a reduction or cessation of drug use.

This article is not intended to advocate for or against either traditional treatment models or harm reduction strategies. The intent of this issue of The Source is to provide information about the philosophy and practical application of harm reduction as an alternative to abstinence based recovery programs. We do, however, encourage readers to consider that in order to meet the diverse and complex needs of the many addicted parents and pregnant women in this country, it may be useful to offer a vast array of services that reflect different treatment philosophies and approaches.

Amy Price
Editor

REFERENCES

The Robert Wood Johnson Foundation’s Substance Abuse Policy Research Program is requesting proposals for research projects that will produce policy-relevant information about ways to reduce the harm caused by the use of tobacco, alcohol, and illicit drugs in the United States. Projects are expected to increase understanding of public and private policy interventions to prevent, treat, and reduce the harm caused by the use of tobacco, alcohol, and illicit drugs, including the advantages, disadvantages, and potential impact of these policies. Projects may address policies at the national, state, or local levels in the public sector, or they may address private sector policies within companies, associations, unions, or trade groups.

Letters of intent for projects requesting under $100,000 will be accepted at any time. Letters of intent for projects requesting $100,000 to $400,000 should be submitted by February 4, 2002.

For more information, go to http://www.rwjf.org
Using Harm Reduction to Address the Needs of Families Affected by Substance Abuse

Nothing epitomizes the public perception of an unfit mother more than a woman using drugs during pregnancy or while parenting. Beyond severe personal and social condemnation and isolation, many women who use drugs also face serious legal consequences—including the loss of their children and/or incarceration. Although it is widely believed that drug use exacerbates harm to women, children, families, and communities, traditional attempts to reduce drug use do not necessarily reduce the harm. Often this is because the interventions do not address the root causes of drug-related harm (e.g., poverty, violence), and/or they are not accessible to or appropriate for women in need of the services. This article discusses the rationale for and application of harm reduction as an alternative approach to working with pregnant and parenting women who use drugs.

A Harm Reduction Approach

At its most basic level, harm reduction works to reduce the harms related to drug use without necessarily stopping the consumption of drugs. While harm reduction acknowledges the very real harms associated with drug use, it recognizes that abstinence-only approaches often fail and ignore a range of actions people can take, short of abstinence, that can significantly improve their and their families’ health and lives. For instance, harm reduction approaches include: providing women with information about the possible impact of maternal drug use on fetal development; engaging them in conversations about substituting less harmful for more harmful drugs and forms of drug use; and providing education and materials for safer drug use.

Harm reduction argues that pathologizing drug users as the cause of social problems distorts the real picture of social and economic policies and realities that place people at greater risk for chaotic drug use. The primary principle of harm reduction is starting with people “where they are at” to define and understand the role of drug use in their lives and the lives of those with whom they are in relationships, including children and other family and community members. For example, by listening to a pregnant or parenting drug user talk about the purpose drug use serves in her life, one can gather valuable information about the person that can help identify interventions that might help immediately, regardless of whether abstinence is possible (Tartarsky, 1998). This information can also be used to help the woman identify less harmful coping mechanisms that serve a similar purpose.

Harm reduction also argues for an increase in the spectrum of services available to all those affected by drug use. For women, this includes a variety of interventions during pregnancy, accessible and appropriate treatment on demand, services to change the context of women’s lives, and interventions to protect children.

Pregnancy as a Window of Opportunity

If the most basic principle and practice of harm reduction is starting with people “where they are at,” then a harm reduction approach would start from the recognition that pregnancy is a time when women are very often motivated to make healthy changes in their lives. Consequently, pregnancy provides a “window of opportunity” for social and health services to support such change.

Despite assumptions that all children prenatally exposed to cocaine are likely to be seriously damaged at birth, and that all drug-using parents are dangerous to their children, research about the short- and long-term effects of cocaine use by pregnant women remains inconclusive. Whereas one recent study of rhesus monkeys suggests that prenatal exposure to cocaine may affect the brain structure in humans (Hunt, 2001), other researchers have found that not all crack-exposed children will suffer permanent mental or physical impairment (Frank et al., 1993; Mayes et al., 1992). Further, current findings indicate that poverty’s impact on brain development greatly overshadows the supposed effects of prenatal cocaine exposure (Hurt et al., 1999), and that other substances—particularly alcohol and tobacco—may cause equal or greater damage to fetuses and young children.

Despite the relatively low incidence and inconclusive evidence of the isolated damage from cocaine use among pregnant women, cocaine and other illegal drug users are often prosecuted and involved with child protection services (Murphy & Rosenbaum, 1999; Hurt et al., 1999; Roberts, 1997). Yet, Murphy and Rosenbaum (1999) found that, contrary to the image of drug-using women as unconcerned mothers, a majority of pregnant women engage in a variety of harm reduction efforts to reduce their drug use and compensate for the presumed detrimental effects of any ongoing use. These self-help strategies include: substitution of
Train prenatal care providers to respect all of their patients. Far too many drug using women report insensitive comments by medical staff, refusal of staff to provide pain medications during delivery, and providers’ ignorance about the value and safety of such things as methadone treatment during pregnancy.

Increase access to culturally relevant drug treatment, mental health and prenatal care services for drug using women.

Make prenatal care and delivery facilities bridges to, or providers of, needed services such as mental health support and drug treatment.

Accessible and Appropriate Treatment on Demand

“Treatment on demand” is a priority for harm reduction advocates. Experience suggests that those who access harm reduction services often seek referral for drug treatment. However, there are not enough treatment programs for substance users in America, and the lack of services is particularly acute for women. Every year in the U.S., there are an estimated 675,000 pregnant women in need of drug treatment, and less than 11 percent of them will receive it (Murphy & Rosenbaum, 1999). Additionally, many drug treatment programs refuse to treat pregnant women, many prenatal care agencies refuse drug using pregnant women, and attempts to secure housing, medical and mental health services often require total abstinence (Murphy & Rosenbaum, 1999; Frank et. al, 1993; Mayes, 1992; Coffin, 1997).

Lack of quality often presents an additional barrier. Quality programs are comprehensive and non-punitive. Quality programs recognize and seek to build on the strengths of a pregnant or parenting woman through the development of internal capabilities rather than exclusively through external motivational techniques of reward and punishment. Quality programs integrate healing from histories of trauma and violence for both women and their children, addressing mental and physical health concerns, including drug use. They also incorporate parenting and job skill development that realistically support women in maintaining capabilities and in decision making processes.

Quality programs should not punish women who continue to use drugs or experience relapses by denying them ongoing services (McMurtrie, 1999). Finally, quality programs do not view relapse as a failure, but as an opportunity to understand the process of recovery and events and circumstances that trigger the desire to use substances.

Although the demand far exceeds the supply, there are some model drugs treatment programs that support women during and after pregnancy and allow women and children to remain together in residential care. At a Sacramento, CA, drug treatment program operating out of a university department of psychiatry, for example, 88% of 70 women using opiates during pregnancy were treated with methadone and delivered healthy children whom they continued to parent successfully. The doctor who created and runs this program noted that its effectiveness can only be achieved when “combining medical/obstetrical care, psychiatric care and drug treatment.” (Paltrow, Cohen and Carey, 2000).

While these program components are integral to any treatment, it is important to have a variety of treatment modalities available to pregnant and parenting women. That is, whereas some women may need and desire residential care, others may prefer integrated “outpatient” services.

Drugs perceived as less harmful for those perceived as more harmful; breaks between binges for sleeping, resting, and eating; taking vitamins and nutrients to “counteract” the negative effects of drug use; and reducing illicit activities to acquire drugs that are thought to be detrimental to the health of the fetus (i.e. sex work).

Instead of building on the concerns many drug using women have for their children, the lack of services and support, as well as the threat of prosecution and loss of custody, have created fear and disincentives for drug-using women to come forward and seek prenatal care and other services. As a result, the women most in need of mental, social and medical services—“those most heavily involved in the drug life—were most alienated from prenatal care” (Murphy and Rosenbaum, 1999). As Murphy and Rosenbaum explain, the pregnant, drug-using woman is faced with an impossible dilemma, “not to disclose may compromise the baby’s health, but disclosure may result in the loss of custody” or, in some instances, incarceration.

Following are strategies to increase the options available to, and the capability of, women who use drugs while pregnant (and parenting) to minimize harm to their children:

- Ensure that women who seek prenatal care can do so without fear of arrest or loss of parental rights.
- Support health care provider-patient confidentiality so that women can discuss their drug problems and other highly stigmatized aspects of their lives with their health care providers, who require the trust of their patients and information about their patients’ health problems.
- Provide information to pregnant women so that their “harm reduction” efforts are more effective. For example, educate them about the effects of alcohol on fetuses so they don’t substitute alcohol for another drug with the misconception that it is less harmful.
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Improved access to a variety of quality drug treatments would likely increase the number of women who participate in recovery services. Additionally, if access to quality health care were increased, fear of accessing prenatal care decreased, and the prescription of methadone by physicians made possible through national legislation, women seeking prenatal care could be connected to integrated services including drug treatment. That is, physicians, mental health and social service providers could collaborate to provide prenatal care and education, mental health services (including the substitution of pharmacological drugs for the management of mental health issues and suffering), parenting education, and more general case management.

Changing the Context of Women’s Lives

Instead of viewing drug use as an indication of the need for more support, drug use has become the rationale to revoke welfare benefits, to refuse health and social services, to deny housing, and to prosecute and incarcerate. As a result, pregnant and parenting women often become further isolated, stigmatized, disempowered and persecuted. At the same time, these punitive responses to drug use by pregnant and parenting women have decreased neither the rates of pregnancy among drug using women.

To support women in being adequate parents, many services and opportunities currently denied to drug using women need to be made available. Addressing issues of employment and housing, for instance, are crucial to ensuring family well-being. Unemployment or employment in the informal sector (sex work, drug sales) make managing drug use or maintaining abstinence unlikely and continue to expose women and their children to all the vulnerabilities associated with poverty. Access to job training is important for drug using, abstinent and non-drug using women alike. Chronic drug use may or may not impair job management, but the chaos of unemployment often due to a lack of formal job skills and training in the lives of many women living in poverty certainly creates impairment.

Additionally, while safe housing is often unavailable to people struggling with poverty, available housing is often refused or revoked once drug use is identified. For single mothers and pregnant women, particularly those whose drug use is known or easily identified, housing is particularly difficult to come by. There has been a growing harm reduction movement to secure housing for drug users, including single mothers and pregnant women, and to change abstinence-only housing policies. This is critical in order to support pregnant and parenting women who use drugs in moving toward greater health for themselves and their children.

A harm reduction approach should also include family planning that helps women to explore the internal and material resources needed and available for raising children. Such discussions include the pros and cons of having a child now versus later.

Additionally, services must be available to address the violence in women and children’s lives. The Lower East Side Harm Reduction Center in New York, for example, has secured resources to provide low-threshold, drop-in and appointment-based, mental health services to participants seeking “someone to talk to” about their histories and about the current difficulties in their lives.

This broader harm reduction approach does not condone drug use, but acknowledges the context in which a woman’s drug use takes place. It recognizes that stabilizing the lives of women and children affected by drug use can do more to reduce harm than isolated, punitive measures to control the drug use alone.

Protecting Children

Clearly there are times when temporary or permanent separation of children from their families is important for the well-being of the children, the parent(s), or both. Unfortunately, children who are removed are often traumatized by the separation and, in some cases, they are put into other unsafe environments. Creative harm reduction strategies may be helpful in protecting some children without unnecessary separation from their families. For example, we can help parents to develop safety plans for their children, i.e., securing alternative care for children before a parent uses drugs. We might explore opening free 24-hour drop off childcare centers in neighborhoods that are most severely impacted by harmful drug use. Such centers would not be a place that condoned bad parenting, but that protected children who needed it (e.g., when parents are “crashing” or recovering from a binge) and made a place where conversation about alternatives could start with the parents.

Professional Training

Cross-training among child welfare, substance use, health and mental health, and housing sectors can begin to create forums for information and strategy sharing, and reduce the lack of coordination so frustrating for families struggling with issues of drug-related harm. For example, the vast majority of child
State Responses to Pregnant Women Who Use Drugs or Alcohol

The following information was excerpted from a report entitled State by state statutes and regulations specifically addressing pregnant women who use drugs or alcohol. This report was prepared by National Advocates for Pregnant Women. For more information or a copy of the complete report, please contact NAPW at 202/234-2812 or http://www.scapw.org

State policies and regulations clearly reflect a view that prenatal exposure to drugs or alcohol is harmful to the unborn child. Many states require an investigation of any pregnant woman presumed or known to be using drugs. In some states, evidence of drug use during pregnancy (e.g., positive toxicology screen of mother or newborn) is considered abuse or neglect. Arizona, Florida, Massachusetts, Michigan, Minnesota, Oklahoma, and Utah, for example, require health care professionals to report to child protective services any newborn who is (or may be) affected by the presence of drugs or alcohol. Illinois, Rhode Island, South Carolina, and Texas consider a positive toxicology screen of a newborn, a medical diagnosis of fetal alcohol syndrome (FAS) or withdrawal symptoms, and/or use of controlled substances or alcohol by a pregnant mother, prima facie evidence of abuse or neglect. Indiana and Nevada also consider a child born with FAS or a controlled substance in his body in need of protection or services, and Minnesota’s definition of neglect includes prenatal exposure to drugs. Maryland’s statute assumes that a child born with a presence of certain drugs is not receiving proper care, and the state proceeds to termination of parental rights if the mother does not enter an offered treatment program within a certain period of time. Texas courts also may order termination of parental rights if the child is born addicted to alcohol or other drugs.

Other states take a less punitive approach. Some specifically note that drug use in and of itself is not grounds for abuse, but it may trigger a report to child protective services and/or further assessment of other risk factors. In California, for instance, a positive toxicology screen at the time of delivery is insufficient to report child abuse/neglect, but does warrant an assessment for other risk factors. Iowa requires health practitioners to report positive toxicology tests to CPS, but clearly states that these tests should not be used for criminal prosecution. Kentucky and Virginia also prohibit positive toxicology to be used as prosecutorial evidence, and Missouri prohibits it from being used to mandate reporting or to prosecute for abuse and neglect. Additionally, Virginia statute states that a child abuse report based on maternal drug use shall not be made if the mother sought treatment or counseling prior to the child’s birth.

While many states take a punitive approach to pregnant women who use drugs, and some require women to participate in drug treatment in order to keep their children, other states have developed policies or programs to provide treatment and other services for these women and their children. State funded substance abuse treatment programs in Iowa, for instance, cannot discriminate against treatment seeking individuals because of pregnancy. Other states (e.g., Arizona, the District of Columbia, Georgia, Kansas, Maryland, Missouri, Texas) go a step further by giving pregnant women priority for drug treatment services. Arizona’s Child Protective Services also has an expedited substance abuse treatment fund to help facilitate family reunification or preservation. Similarly, Pennsylvania’s Department of Public Health offers grants to organizations to provide comprehensive services to substance using pregnant women. California has various efforts to support this population including a pilot program to fund services for alcohol and drug abusing pregnant and parenting women and their infants, and a Pregnant and Parenting Women’s Alternative Sentencing Program. Connecticut established a program to provide indigent uninsured pregnant women access to health care including substance abuse treatment. Similarly, Oregon developed pilot programs in local health departments to address the substance abuse-related health problems of pregnant and post-partum women and their infants.
Mothering is a social role with tremendous responsibilities, precious little preparation and ambiguous standards of good practice. People do not necessarily know how to tell a woman to mother, but everybody seems to know when she is doing it wrong. Being labeled an “unfit mother” has horrendous social consequences of personal and social condemnation and social isolation.

Psychoanalyst Estella Welldon (1988) described the difficulties mothering presents for women:

Women are expected to carry out the difficult and responsible task of motherhood without having had much, if any, emotional preparation for it. Their responsibility is to bring up healthy and stable babies who will adapt happily to growing external demands. Mothers are expected by society to behave as if they had been provided with magic wands which not only free them from previous conflicts, but also equip them to deal with the new emergencies of motherhood with skill, precision, and dexterity (1988:17-18).

The challenging job of mothering is further complicated by drug problems. Thus, while all mothers need some support, women who use drugs may need a greater level of assistance in order to effectively care for their children. With comprehensive and humane interventions, however, drug using women can be adequate parents.

Realities of Drug-Using Mothers

In a recent NIDA funded study, most of the drug using mothers or mothers-to-be that were interviewed were victimized or brutalized as children (Murphy, 1995-1998). They were violated through incest, molestation, rape, and battering. Some were removed from family homes due to violence or abuse only to be abused and violated in subsequent settings. Unsafe and unstable home environments pushed women out of family homes in early or late adolescence. Women then faced a myriad of problems resulting from racism, poverty, teenage pregnancy, lack of education, and chronic unemployment. When they worked, they were segregated into primarily monotonous, menial, and minimum wage jobs. Then illegal drugs came into their lives.

Some women use drugs as a resource to endure the myriad of problems they face; they self-medicate with alcohol, illicit drugs, and tobacco in order to cope. Drug use makes life more manageable by alleviating physical pain, while acting as an emotional analgesic as well. Drugs are also a source of recreation, a chance to have some time out or to party. Women provide drugs for their partners to keep them happy, hoping to ward off or postpone violent episodes or abandonment. Drug use also gives them a sense of control, if only over their own consciousness, in circumstances where they have very little (Sales and Murphy, 2001).

Amidst these circumstances, women face imminent motherhood. Given women’s primary responsibility for childbearing and rearing, the conflicting social roles of mother and drug user create an atmosphere of continuous tension for drug using pregnant women and mothers. They are under pressure to juggle their time and energy between the requisite responsibilities of motherhood, like making sure the kids are fed, and drug-related tasks, like selling their bodies for drugs, finding dealers and using. In addition to the ongoing juggling act, they have to deal with the risks of encountering violence during their associations with drug users.
The concept of adequate parenting is often approached from an ecological perspective (Belsky, 1984). Ecology theory suggests that parental availability and responsiveness is in part a function of the supports that caregivers receive from larger systems. When caregivers are supported by social systems, including extended family members, friends, community, and organizations, they are potentially more available to effectively interact with their children. While parental support from larger systems has been shown to be effective in increasing parental availability in non-substance abusing mothers (Crockenberg, 1981), there is minimal information on the effectiveness of larger systems in supporting parental emotional availability in substance-abusing mothers. However, there is some information suggesting that low-income drug-abusing women are less sensitive and less responsive in the caregiving of their children than non-drug abusing women from the same demographic background (Beckwith, Howard, Espinosa, & Tyler, 1999). Additionally, children of actively substance using women tend to do more poorly developmentally than do those of non-substance-abusing women (Johnson, Glassman, Fiks, & Rosen, 1989).

Needs of Children

In discussing adequate parenting, it is imperative to consider the needs of children. For the most part, children’s needs do not change no matter what the parental circumstances. Therefore, for this discussion, “adequate parenting” will be defined as the ability to meet children’s needs.

Our goals for children are for them to be healthy, happy, respectful, confident, cooperative, and responsible as they progress through childhood (Dinkmeyer, McKay, Dinkmeyer, & McKay, 1997). We also want them to be healthy and appropriately socialized as they grow into adulthood. Their childhood experiences serve as preparation for life as an adult (Erikson, 1963). In order for children to emerge from childhood in optimal health and with the personal/social skills to function effectively in society, we must provide for them a nurturing environment that is developmentally appropriate for them. Through this process parents must respect their children as individuals, admire their accomplishments, give them unconditional love, communicate with them, encourage intellectual development, discipline them, and teach them values (Davidson & Davidson, 1996).

Health and physical safety are basic needs for optimal child growth and development. Children must have adequate nutrition, appropriate healthcare, and be protected from environmental hazards. Children who are healthy and who are kept safe are generally more adept at exploring their world and learning. While poor health alone does not preclude optimal development, it is important that parents are aware of the health concerns of each of their children, are available to generate supports to meet the children’s health care needs, and are informed and available to execute any in-home procedures (e.g. treatments for asthma) to optimize child health.

Child health and safety also encompasses both home safety and protecting the child from environmental hazards outside of the home. Keeping children safe often requires some knowledge of child development on the part of the parent in order to be aware of age-appropriate expectations regarding children’s understanding/ recognition of dangerous situations. For instance, infant car seats and seat belts should be available, in proper working order, and consistently used when children are riding in vehicles.

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**YES**

dealers, customers, pimps and johns. Worse yet, many of these women are involved in abusive intimate relationships and have the added burden of having to do everything in their power to make their partners happy in the hopes of avoiding the next violent outburst (Sales and Murphy, 2001).

**Underlying Issues**

Clearly, these are not ideal situations in which to raise a child; and it is not inappropriate to question the ability of a parent in these circumstances to adequately care for his/her child. However, we argue that it is not the drug use itself that creates the greatest harm for the child. Our unrealistic social expectations for women, hiring discrimination, and lack of a national health care system and social services for women and children, all conspire to block legal and healthy routes to satisfaction and well-being. Women’s drug use cannot be understood apart from the social and economic contexts in which these experiences are embedded. In fact, poverty, violence, hardship and desperation are the greatest threats to effective parenting and child survival. Why, then, do the media, interventionists and policy makers focus so much attention on mothers’ drug use?

During the last two decades, pernicious images of drug using mothers having babies for the sole purpose of qualifying for government handouts in order to buy drugs and then neglecting and abusing these children were promulgated by the media and politicians (Campbell, 2000; Humphries, 1999). This contributed to the passage of legislation and funding allocations that resulted in the wholesale reduction of social welfare services to all poor women and children (Besharov, 2000). The war on drugs has always been a war on the poor, particularly poor people of color (Murphy and Rosenbaum, 1999; Roberts, 1997). However, researchers have demonstrated that some women who use illicit drugs can be adequate parents if they have sufficient medical, social and economic supports (Boyd, 1999; Kearny, 1994).

**Solutions**

Legislative, legal and political practices that impede a mother’s continuing contact or involvement with her children, or send her to jail, do not support the relationship critical to the stability and well-being of both the mother and child. Rather than indicting women who use drugs for their addictions and compulsions, we would do well to address the challenging conditions from which women and their children find it difficult to escape. For instance, women with children would benefit from policies that support families by providing guaranteed family income, housing, help with employment and other sorts of ancillary services. The institution of a national health service, which includes women and family-oriented drug treatment, would help to ensure that all women and their children have access to comprehensive health care. Health and social welfare programs enabling families to stay together while a mother receives education, drug treatment, and help with parenting are promising steps toward positive futures for children. However, help that is predicated on the immediate discontinuance of all drug use is unrealistic. Many parents may, for a variety of reasons, avoid or have difficulty adhering to abstinence based programs despite their concern for their children. Harm reduction services for mothers who use illegal drugs can help to improve the health and circumstances of these women and reduce the subsequent harm to their children. Specifically, mothers’ incremental behavioral changes (e.g., reduced use, changing from injecting to inhaling, attending drug treatment, making safety plans for their children) must be rewarded. Drug substitution and supplementation also must be explored—not just methadone instead of heroin, but for example medical marijuana to help a woman reduce or abstain from alcohol or crack use. With sufficient services, even if a parent is not totally abstinent, “gains may be made in areas such as quality of communication, employment and better parenting” (Collins, 1990, p. 286).

**Conclusion**

Experience suggests that separating a child from his parents can be extremely traumatic. There is also a tremendous shortage of foster and adoptive homes. Therefore, removing a child from his parents solely due to their drug use may not be a viable or desirable solution. Although this may be necessary in some situations, other children can safely remain within their families. The decision about child removal should be based on the child’s well-being which reflects the parents’ behavior and ability to care for that child regardless of their drug use. Harm reduction strategies that support parents by providing economical and social alternatives to their current lifestyles and addressing their health and psychological needs can help to ensure that parents who use drugs can

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Further, there must be appropriate supervision of children during outings, and parents must be able to critically evaluate the safety and appropriateness of other caregivers with whom they may wish to leave their children.

Promoting optimal socio-emotional development for children begins in infancy and is supported throughout childhood. Infants who have an emotionally available and sensitively responsive caregiver are more adept at emotional regulation (Yoshikawa, 1994). This proficiency with emotional regulation has been reported to form the basis for positive socio-emotional development as the child grows. Infants who experience disruptive or poorly functioning early caregiving environments are at risk for emotional dysregulation and later behavior problems (Yoshikawa, 1994). Also, young children who have experienced abuse have been found to have emotional dysregulation, affective lability, and socially inappropriate emotional expression that may contribute to later reactive aggression (Sheilds & Cicchetti, 1998).

Children's intellectual and socio-emotional development is influenced by their early experiences with attachment related to their primary caregiver (Ainsworth, Blehar, Walters, Wall, 1978; Egeland & Farber, 1984). Secure attachment is supported when the primary caregiving figure is consistently available and sensitively responsive to her young child's overtures and cues (Egeland & Erickson, 1987). Securely attached children show positive socially adaptive behaviors as toddlers (Egeland & Farber, 1984). Those who have experienced an unavailable or inconsistently responsive caregiver are at risk for exhibiting maladaptive behaviors consistent with insecure attachment (Ainsworth, Blehar, Walters, Wall, 1978). Children with an insecure attachment are at risk for later poor intellectual and mental health development, and abused and neglected infants and toddlers are at risk for an insecure attachment (Ainsworth, 1980; Crittenden & Ainsworth, 1989).

As children move past the first three years of life into the preschool and school years they have more contact with the larger world outside of the home. However, the home environment continues to set the tone for the child's development. As children have increased language and communication skills, it is important for parents to be available and sensitive to their children's feelings to aid them in defining their feelings and in coping with their feelings in socially appropriate ways (Dinkmeyer, McKay, Dinkmeyer, Dinkmeyer, & McKay, 1997). Parents also need to be available to set consistent and age-appropriate limits, to model appropriate or desired behaviors, and to reinforce expected or desired behaviors.

Impact of Drugs on Parenting Ability

Addiction is a chronic, progressive disease with a “loss of control” over the use of the addictive substance, despite the presence of negative health, psychological and social consequences (Ruden and Byalick, 1997). The addicted person's primary relationship is with their drug of choice. This relationship takes priority over the relationship with their children. When parents are engaging in the lifestyle surrounding drug addiction, they are less likely to be sensitively responsive to the needs of their children (Beckwith, Howard, Espinosa, & Tyler, 1999).

During periods of abstinence, mothers may consistently and sensitively respond to their children's needs. However, drug use exerts an affect on the central nervous system that may cause “altered” states such as excitation or somnolence (Ruden and Byalick, 1997). When a mother engages in occasional use of drugs and is in an altered state of mind she is more likely to be emotionally unavailable to interact with her children in a consistently, sensitive and responsive manner while under the influence of the drug. Also, there is a concern about relapse when individuals who have a history of drug addiction are not abstinent (Ruden and Byalick, 1997). Whether drug use is occasional or heavy, the parent is often inconsistently available to appropriately interact with his/her children while under the influence of the drug. This inconsistent parental availability can contribute to the children's emotional dysregulation (Yoshikawa, 1994), insecure attachment (Ainsworth Blehar, Walters, & Wall, 1978), and behavioral difficulty (Sheilds & Cicchetti, 1998).

Also of concern with regard to the parenting abilities of drug abusers is the high incidence of “dual diagnosis” in individuals who are substance-abusing (Kessler, Nelson, McGonagle, Edlund, Frank, & Leaf, 1996). “Dual diagnosis” refers to the co-existence of drug addiction and another mental health disorder (Riley, 1994; Schottenfeld, 1993). Substance abuse is associated with a wide range of psychological disorders, including affective disorders, personality disorders, and psychoses (Sports & Shontz, 1991). Mental illness

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ADAPTATION OF THE HEALTHY FAMILIES AMERICA PROGRAM TO FAMILIES AFFECTED BY DRUG USE: A USE OF THE HARM REDUCTION MODEL

Best Beginnings, a Healthy Families America home visitation program, was started in 1994 in two census tracts in the Washington Heights area of Manhattan, New York, and has expanded over the years to keep up with the need for services within the target area. Best Beginnings is a collaboration of Alianza Dominicana, Inc., the New York Society for the Prevention of Cruelty to Children (NYSPCC), and New York Presbyterian Hospital. NYSPCC provides the staff with guidance and legal consultations regarding child protective issues and stand-by guardianships, if necessary. New York Presbyterian Hospital provides a direct link with medical providers and social service staff. Alianza Dominicana, Inc., the largest Dominican social service agency in the nation, provides a woman-centered drug treatment program (CREO), day care, housing assistance, Medicaid application processing, and welfare advocacy.

The Healthy Families America model (Daro & Harding, 1999) is an adaptation of the Healthy Start program from Hawaii (Breakey & Pratt, 1991). The goals are primary prevention of child abuse and neglect and building healthier families. The home visitation service is offered by Family Support Workers—paraprofessional women from the community who receive extensive training and close supervision. This mode of service delivery has been found to be particularly effective with hard-to-reach families. Because of the focus on primary prevention and the use of paraprofessionals, however, the Healthy Families America model was considered unsuitable for working with families affected by substance abuse or mental health issues. Best Beginnings challenged this notion by adapting the home visiting model for use with families affected by substance abuse. We developed a new framework that combines the principles of harm reduction with the key elements of the Healthy Families America model. We call this combined model Best Beginnings Plus.

Harm Reduction Model in Best Beginnings Plus

Best Beginnings Plus is a user friendly, family centered approach to home visiting with substance affected families. The Family Support Worker works with the participant and the family to reduce the harms of licit and illicit drug use on the individual, the child/ren, the family, and the community. The Family Support Worker meets the participant where s/he is at, even during the participant’s active drug use. The goal is to offer information and education so that the participant can make an informed choice. To this end, the Family Support Worker offers the participant access to a host of resources when in need and upon request. Receipt of services is independent of any drug-related behavior on the part of the participant, such as not keeping appointments or disappearing for days. The approach is also explorative in orientation. It allows the participant to use the Family Support Worker as a sounding board to explore the potential effects of a given behavior on herself, her child, and her family. Finally, it is solution-focused in meeting the participant’s goals, thus reducing the stigma associated with services. Harm reduction is congruent with the Healthy Families America critical element that states that the service is voluntary. Additionally, Healthy Families America and harm reduction have many elements in common. Both:

- are strength based;
- respect individualism;
- seek to maximize social and health assistance;
- accept the participant as a competent, equal partner;
- offer support;
- respect self-determinism;
- assist in exploring options and alternatives; and
- are educational in orientation.
FOR WHOM IS IT APPLICABLE?

Healthy Families America and harm reduction appear to be a perfect fit for providing services to certain types of substance affected families. On a continuum of drug use, this combined model is applicable to individuals in the experimental or recreational phase of drug use and to those who are in the early stages of “controlled” use. By working with individuals in these early phases, one can prevent them from moving on to the substance abuse phase.

The presence of a child is used as a strong motivating factor to prevent parents from progressing along the continuum of substance abuse. At more advanced stages of drug dependency, it is often not possible to motivate the user by means of the child. Further, the presence of the child and issues of child safety do not allow us to work with families further along the continuum, where there is no control over the drug use.

The target population for Best Beginnings Plus is: a family in which there is current drug use by any family member living with a child, and/or a history of drug use by either parent. Most of the individuals we have worked with have been using marijuana or cocaine (not crack).

Implementation of Harm Reduction within Best Beginnings Plus

"The overall aims of Best Beginnings Plus are to reduce stressors that may hinder the child’s development, and to minimize the risk of child maltreatment and the potential harms of drug use on the individual and family" (Guterman, 2001). Services are provid-

Strategies for Working with Families Affected by Substance Use

PRENATAL
- inform participant of effects of drugs on the fetus
- schedule visits when participant is most likely not to be under the influence of any substance
- engage in prenatal classes
- make condoms available
- set goals with participant regarding the pregnancy and delivery

POSTPARTUM
- make safety plan for the infant
- make pediatric appointment and accompany the participant
- identify alternate primary caregivers and engage them in home visits
- engage peer group during home visits
- engage participant in workshops and other program activities
- make condoms available
- provide information about physiological and psychological effects of the drug on the individual
- help participant explore her environment and discuss ways to use whatever is available to promote child development
- make sure to observe participant holding, feeding or carrying baby during the visit
- increase participant’s sense of self-efficacy/parenting efficacy by finding 10-20 positives during the visit
- set goals with the participant regarding the child

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STAGES OF CHANGE

In addressing the participant’s drug use, the Prochaska and DiClemente Stages of Change (1983) concepts are used. Beginning with the pre-contemplation stage, the Family Support Workers are trained to listen for cognitive dissonance and to use motivational interviewing techniques to help the participant think about his/her drug use. The Worker initially externalizes the reasons for contemplating a reduction in consumption. For example, the unborn or newly born baby becomes the leading force in moving the participant from a pre-contemplative state to a contemplative state of change. The Worker begins to provide information on the importance of the parent-child bond for child development and helps the participant begin to identify how his/her drug use may affect that relationship. They then help to identify what changes, if any, the parent would like to make.

The Family Support Worker then begins to use the participant’s strengths to move her into action. It is crucial that, once the participant has started to decrease drug use and his/her self-esteem has increased, the Family Support Worker helps her/him begin to internalize reasons to continue making the positive changes that s/he has identified. These changes may or may not be abstinence but a gaining of control of his/her life and drug consumption.

Evaluation of Best Beginnings and Best Beginnings Plus

METHOD

In order to measure the effectiveness of the Best Beginnings Healthy Families America home visiting program and the combined Best Beginnings Plus model embedded within it, a randomized trial is being conducted. All pregnant women and mothers with newborns who live in the target area are screened for risk factors for child abuse and neglect and then assessed with the Kempe Family Stress Checklist (Murphy, Orkow, & Nicola, 1985). If they score in the at-risk range, they are randomly assigned to the Program group, which receives intensive in-home services, or to the Control group, which receives home visits twice a year to assess the need for services, make referrals and collect follow-up data. If, during the Kempe interview, information is provided that indicates that there is substance use in the family, they are enrolled in the Best Beginnings Plus component. These families are randomly assigned in the same fashion as the non-substance affected families. However, Program families receive the full Best Beginnings Plus intervention as described above.

In order to measure the effectiveness of the intervention, information is collected at regular intervals by the Family Support Workers or the Child Developmentalist on the following domains: maternal depression (the Center for Epidemiological Studies Depression Scale (CES-D) (National Institute of Mental Health, 1977); infant mental/cognitive and motor development (Bayley Scales of Infant Development, Bayley, 1993); the caregiver’s sensitivity and responsiveness to the child and the child’s clarity of cues and responsiveness to the caregiver (Nursing Child Assessment Satellite Training (NCAST) Teaching Scales, Barnard, 1978).

Results and Discussion

DEPRESSION

Data from the measure of maternal depression show a positive trend in substance using women receiving the Best Beginnings Plus intervention. At intake (prenatally), the women in the Program group scored higher (i.e., were more depressed) than the women in the Control group, but by the post-partum period, their scores had dropped to within the normal range, whereas the Control group scores had remained the same. By six months post-partum, the scores of both groups had decreased, but the Program group scores continued to be lower than the Control group scores. Depression can be a major interfering factor in a woman’s attempt to relate to and nurture her newborn infant and is a persistent predictor of child abuse and neglect, leading to child placement (Chaffin, Kelleher, & Hollenberg, 1996). The Best Beginnings Plus Program women who received supportive home visits during pregnancy were less depressed and more open to taking on the tasks of motherhood.

INFANT DEVELOPMENT

Follow-up assessments of the infant’s development as measured by the Bayley Mental Development Index

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Christina, a 17-year-old African American female, was recruited in March 1997 on the maternity ward of an inner city community hospital. Christina had given birth to a six pound, six-ounce baby girl named Taisha. Christina agreed to participate in Best Beginnings and completed the Kempe Assessment indicating a negative history of drug use. The Family Support Worker assigned to her and the supervisor went to meet Christina at the hospital where they were greeted by Christina and Jesse (Taisha’s 18-year-old father). Jesse proudly showed them that he had bought his daughter a bottle. The opportunity to engage Jesse in services was seized and he agreed to cooperate. Although Jesse and Christina were not living together, and he was not able to financially provide for her, Jesse expressed his desire to help with his baby. During this visit, breastfeeding and family planning were discussed.

The Family Support Worker made a home visit the subsequent week. At that time, Christina resided with her mother and her three-year-old nephew in a one-bedroom apartment. The family’s only source of income was public assistance. Christina was in 10th grade and contemplated returning to school after the birth of her daughter. However, due to lack of childcare, she was not able to. Christina and her mother had a conflictual relationship. Her mother had many complaints about Christina, and Christina had issues with her mother’s alcohol consumption. Christina’s mother was not a feasible source of support for Christina and her daughter, Taisha. However, Christina’s mother’s concerns regarding Christina’s “hanging out” raised the issue of drug use. The Family Support Worker and supervisor made a home visit that same week, and asked Christina what methods she and Jesse used to “get in the mood.” Christina disclosed the use of marijuana, however denied current drug use. Immediately, conversations regarding other methods of eroticizing the relationship were held so as to provide Christina with means other than marijuana of “getting in the mood.” Condoms were also provided.

Thus, Christina, a young mother, presented with financial difficulties, a conflictual relationship with her mother, and a limited support system, mainly from Jesse. In the subsequent weeks, the Family Support Worker focused on Christina’s and Jesse’s relationship with Taisha, providing them with information on parent-child interaction and engaging them in Best Beginnings activities. Both Christina and Jesse soon trusted their Family Support Worker, and both disclosed continued use of marijuana. The Family Support Worker provided Christina and Jesse with information on the effect of second hand smoke and the effects of marijuana on the individual, particularly how it impairs one’s judgment. A safety plan was developed for Taisha in which both parents agreed that they would alternate responsibilities, and only one “would hang out at a time.” Christina’s relationship with her mother deteriorated, causing her to move out of her mother’s apartment several times. Jesse continued residing with his grandmother throughout this entire period of time, providing Christina and Taisha with a stable person in their lives. With Christina’s and Jesse’s permission, the Family Support Worker quickly made contact with Taisha’s great-grandmother and engaged her in assuring Taisha’s well-being. As Taisha grew, Jesse’s and Christina’s sense of efficacy as parents improved, increasing their self-esteem and gradually decreasing their drug use. Christina and Jesse, with Jesse’s grandmother’s assistance had embarked on the journey of parenting.

Christina had many transitions in and out of her mother’s apartment, until finally she moved in with Jesse and his grandmother. Jesse and Christina secured public assistance and entered a family shelter. They have subsequently moved up to Tier I Transitional Housing and are awaiting their own apartment, a major accomplishment.

During Christina’s participation in Best Beginnings Plus, Taisha completed her twice yearly developmental assessments. All of Taisha’s well baby visits were completed and her immunizations were up-to-date. Using Taisha as the focal and primary point of service, the Family Support Worker helped Christina and Jesse find support in one another and control their use of marijuana. Their relationship became stable and their commitment to Taisha provided them with the ability to decrease and control their marijuana use.
(MDI) and Psychomotor Development Index (PDI) are available through 30 months. Due to the small number of subjects in the Best Beginnings Plus Control group, it is not possible to draw any firm conclusions. However, it is possible to compare the Best Beginnings Plus Program group (Plus) to the basic Best Beginnings Program group (basic) and see positive trends. The Plus Program group infants have higher mean MDI and PDI scores than the Basic Program group infants at every time point except one, through 30 months of age. A formal statistical analysis of this result will have to await larger numbers, but it is interesting to consider the possible reasons for this trend and its implications. Input from direct service staff working with the Best Beginnings Plus families indicates that many of the younger drug users are very concerned about the development of their infants and are motivated to do whatever possible to promote their healthy development. The Family Support Workers provide the mothers and other caregivers with tools for working with their infants. The control group mothers on the other hand, many of whom may have the same motivation, are not given the tools to achieve their goals.

Support for this hypothesis comes from analysis of the mother-infant interaction data (NCAST scores) at 6 and 12 months. The Best Beginnings Plus program families scored higher than the Best Beginnings Plus control families on the maternal Cognitive Growth Fostering scale at both time points, achieving scores similar to the basic Best Beginnings program families. A similar pattern was found for the maternal “Response to Distress” subscale. These tentative findings suggest the potential power of the intervention to mitigate against the possible negative effects of drug use on the fetus and child, and they are congruent with the statement by Karr-Morse & Wiley (1997, p.61) that “most crack babies who were placed in nurturing and stimulating foster care or adoptive homes now perform normally and are generally indistinguishable from their peers.”

OTHER FINDINGS

In addition to analyzing the effectiveness of the intervention by examining the results of the randomized trial, we used more traditional yardsticks. Over the four-year period, 41 families were enrolled in the Best Beginnings Plus component. During this time, none of the participants entered formal drug treatment. Since none of the participants was at the stage on the continuum where they were using daily, standard drug treatment programs would not have been suitable.

Two families had children removed. In one case, the two children were returned after the parents went for counseling. In the interim, the children were placed with the maternal grandmother. The Family Support Worker visited the grandmother regularly and worked with her on child development and “parent-child interaction.” Whenever possible, the Family Support Worker also worked with the mother who was allowed to visit her children. Thus, the mother continued to develop her relationship with the children, so that when they were returned, there was a smooth transition. In the other case, the children were removed permanently, but not specifically because of drug use. The mother had multiple issues including mental illness in addition to her drug use.

Summary

We have presented a model illustrating how the principles of harm reduction can be applied to adapt the Healthy Families America model for families affected by substance use. Preliminary results using this combined model indicate that the mothers may show less depression and that the infants who received weekly home visits exhibited advanced cognitive development. Further work needs to be done to refine the intervention, but these initial results are promising and indicate that this clearly is a direction worth pursuing.

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Sobeira Guillen, Program Director

REFERENCES


Harm reduction (HR) is a compassionate public health approach to help achieve the best possible health outcomes currently possible for individuals, families, and communities. In general, it involves assisting clients to substitute less risky drug use behaviors for those they are currently using. As an approach to prevention and treatment of substance abuse, and prevention of infection related to injection drug use, it is grounded in pragmatism, innovation, and balancing public interest with personal freedom. However, HR remains controversial because of limited controlled research on its efficacy, and because it is ideologically counter to enforcement-based substance abuse prevention strategies promulgated as part of the “war on drugs” in the United States.

Nevertheless, HR approaches have gained favor in the drug and alcohol treatment community. Some authors have maintained that HR is “quickly taking hold as a middle-road alternative to the two established traditional approaches favored in this country: the moral model (War on Drugs) and the disease model of addiction” (Marlatt, 1996). HR approaches are believed to minimize the negative impact of drug use on community social service and legal systems by reducing financial burdens associated with traditional drug treatment and incarceration. The RAND Corporation’s Drug Policy Research Center made the recommendation in 1995 that “the principal goal of drug policy be…to reduce the harms to society arising from the production, consumption, and control of drugs,” (Reuter and Caulkins, 1995) thus broadening the scope and applicability of HR principles.

Harm Reduction in Families with Young Children

In the context of substance abuse prevention with families in which there are young children, the HR approach favors helping families who choose to continue using drugs to do so in a manner that minimizes the health and social consequences for them and their children. The Los Pasos Program in Albuquerque, New Mexico, has expanded this traditional application of harm reduction to other public health issues encountered in families with young children. Many of the families served in our program have children at significant risk of abandonment, abuse, and neglect as a result of problems such as: ongoing drug and alcohol abuse by caregivers, neurobehavioral anomalies in the infant, homelessness, exposure to violence, mental illness, and ineffective parenting. Most of these issues are exacerbated by a multi-generational history of poverty. The following discussion is intended to stimulate thinking about the application of HR principles to some of these issues.

HARM REDUCTION STRATEGIES TO ENGAGE FAMILIES

A HR approach to drug abuse prevention, or the prevention of child abuse and neglect, is helpful in engaging families and achieving positive outcomes. This has been our clinical experience and appears to be supported by research. Monti and his colleagues at Brown University conducted a brief intervention, utilizing motivational interviewing, with the intent of reducing alcohol-related harm with adolescents seen in an emergency room setting following an alcohol-related event (1999). The clinician in this case was cast in an “empathic” role as helper and advocate and did not come to the therapeutic alliance with a solidified agenda that could run counter to the client’s expressed needs or goals. Complete elimination of alcohol use was not the aim of this project. However, significant positive impact on subsequent alcohol-related injuries, social problems, drunken driving and traffic violations—the actual intent of the project, was achieved and sustained at six-month follow-up.

Drug use by a woman during pregnancy, which results in referral to the state child protection system and/or specialized programming for the infant and mother, can be conceptualized as a similar “teachable moment” in which to address parenting and health care issues. Drug using women are more likely to seek adequate prenatal care from health care systems that do not adopt a punitive approach, and they are, therefore, more likely to deliver healthy babies and meet health care goals for their infants (e.g., completed immunizations). Our own research with respect to infant growth parameters at birth, and our clinical experience, have shown this to be the case (Hsi, Evans & Steele, 1994; Hsi, Evans &

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Curet, 1996). A HR approach also encourages the establishment of small, achievable goals that may serve a long-range goal of problem resolution like complete drug abstinence. Examples include using less of a particular substance, reducing the number of different substances used, eliminating substances that exacerbate other health problems, or changing the mode of ingestion.

**IMPACT OF HARM REDUCTION ON CHILDREN**

Less widely researched are the direct consequences for the child of ongoing parental drug abuse. Just as efforts might be made to prevent overdose in IV heroin users through needle exchange, efforts can be made to help parents who use illicit drugs keep them out of the reach of children. Users of illicit drugs typically do not keep their supply of drugs in the medicine chest in child-proof containers, where they would be out of reach of young children but also readily available to police or potential thieves. Preferred hiding places (under sofa cushions, etc.), which are chosen for concealment, are more easily accessed by children. Engaging clients within a HR framework is more likely to generate a frank discussion of these issues and ultimately prevent child morbidity and mortality. Should our hospitals and clinics be ready to dispense empty childproof medicine containers to parents who request them?

HR principles can guide other day-to-day decisions families make that impact the health and safety of their children. For example, research suggests that certain co-sleeping arrangements and behaviors (sofa sleeping, cigarette use, exhaustion, and use of a duvet) are associated with increased risk of Sudden Infant Death Syndrome (SIDS), while others (nonsmoking parents) are neutral, and still others (sharing a room with parents) are associated with decreased risk of SIDS (McAfee, 2000). Some families with young children will be best served by a clinician in the role of advisor who assists the family in identifying and minimizing the risks associated with the sleeping arrangement they have decided to pursue. This would involve structuring the environment to minimize the risk of entrapment of the infant, and avoiding soft bedding and parental alcohol or drug use in the evening. Dr. McAfee draws a conclusion that rings true for many other risk behaviors that parents engage in where our attitude as clinicians may be pivotal in helping them reduce harm: “for now, we should avoid turning co-sleeping into an underground activity that parents are afraid to tell their physician about for fear of condemnation.” He goes on to say that “attempting to discourage all forms of co-sleeping based on present evidence would be like trying to talk parents out of ever driving anywhere with their children rather than encouraging proper car seat use” (McAfee, 2000).

HR strategies are also applicable to other daily life decisions ranging from budgeting to maintaining personal safety. A parent who spends her monthly income on cocaine, expensive cosmetics and junk food is at risk of losing her housing for nonpayment of rent. She may choose to eliminate some purchases or reduce her drug use slightly to avoid the “harm” of homelessness. Parents who are intoxicated may have someone else take them and their children to pediatric clinic appointments; the “designated driver” is presumably better able to understand medication instructions than the intoxicated parent. A parent may take his children to multiple alternative caregivers when he is using drugs. Parents who live in high-crime neighborhoods may prohibit their children from playing outside unsupervised. Each of these decisions is in some way protective of children’s well-being, and represents a positive change in parent behavior minimizing potential for harm.

Using existing family resources to ameliorate problems where the family is unable or unwilling to access specialized services is another area for the application of HR principles. A family with a young child needing early intervention services for a cognitive/language delay, for example, may prefer to have an older sibling with an interest in reading read to the younger child in the family setting. While this may not be optimal from the view point of many early intervention professionals, it is a reasonable alternative to no services at all.

**Challenges and Conclusions**

Denning (2000) has characterized harm reduction as “what we do already” that we simply do not conceptualize that way. She cites the example of immunizing young children to reduce the number and severity of infections they are subject to in a preschool or school setting. With this in mind, perhaps we need to step back and ask ourselves what else can we do to reduce harm to children, regardless of the context of the behavior.

Because there is still such limited understanding of what HR is and is not, programs that apply its principles in daily practice may need to devote energy to managing their public image and avoiding misimpressions in the professional community. In addition, the use of HR principles may require
longer time frames and considerable innovation to help families achieve certain goals. Using more traditional approaches, clinicians may help clients achieve short-term abstinence from illicit drugs but may not address root causes or potentially harmful behaviors. Using HR principles, clinicians can help families modify long-standing drug abuse patterns or behaviors toward sustainable ones that are more compatible with good health and parenting.

Opponents of harm reduction applied to the use of illicit drugs voice concern about the undermining of a vital public health message: that nonmedical drug use of any kind is unacceptable (DuPont, 1996). We want to continue to send the message that reduced drug use or abstinence is desirable and possible, for those who want to achieve it, for practical (health, social, legal, and financial) reasons rather than moral ones. We would also like to send the message that reducing harm to children is of paramount importance.

Despite our positive experiences with HR strategies, we recognize that “one size does not fit all.” Harm reduction may not be the right approach for every individual, family, or community, and there is ample evidence that punitive approaches are the only effective approach for some individuals. Different personal histories and cultural differences may also make HR the wrong approach for some individuals at a particular point in time and the right one at another.

Along with exploring the applicability and challenges of HR, we are challenged to gather and disseminate good information about the effectiveness of the HR approach. This task proceeds from a sound assessment, in epidemiological terms, of the health and social costs we are trying to impact. Only then can we “focus our efforts on reducing the actual negative consequences and on truthfully educating the public” (Duncan, Nicholson, Clifford, Hawkins, & Petosa., 1994).

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REFERENCES

CALL FOR ARTICLES
The National Abandoned Infants Assistance (AIA) Resource Center is soliciting articles for the summer 2002 issue of The Source. The Center publishes this newsletter several times per year and distributes it to over 2,000 administrators, policy makers, and direct line staff throughout the country.

The summer issue will focus on peer workers. Individuals are encouraged to submit abstracts for articles that discuss: (1) the challenges and benefits of employing peer workers in programs for families affected by substance abuse and/or HIV/AIDS; (2) how to incorporate peer workers into such programs (e.g., roles and responsibilities, recruitment, and boundary issues); and (3) training and supervision of peer workers. To be considered for publication, please send/fax/email a brief (150-200 words) abstract of your proposed article to the AIA Resource Center at the address or email below. Abstracts are due no later than Thursday, January 31, 2002. Authors of accepted articles will be notified within a few weeks of the deadline.

Send Abstracts and  
Direct Questions to:
Amy Price, Editor  
National AIA Resource Center  
1950 Addison Street, Suite 104  
Berkeley, CA 94704-1182  
Fax: (510) 643-7019  
Phone: (510) 643-8383  
amyprice@uclink4.berkeley.edu
On October 1, 2001, the following fifteen programs were awarded four-year grants from the U.S. Department of Health and Human Services’ Children’s Bureau under the Abandoned Infants Assistance (AIA) legislation.

**COMPREHENSIVE SERVICE DEMONSTRATION PROJECTS**

**Mission Inn** provides home-based infant mental health services, case coordination and other services to families with infants and young children who are abandoned or at risk of abandonment primarily due to substance abuse or HIV/AIDS.

**CONTACT:** Arbor Circle Corporation
1101 Ball Ave., NE
Grand Rapids, MI 49505
Ph (616) 458-2133
Fax (616) 458-5430

**Great Starts** provides comprehensive residential and day treatment for drug using and/or HIV positive women, who are pregnant or have given birth to drug-exposed and/or HIV positive children, and their families.

**CONTACT:** Child and Family Services of Knox County, Inc.
2601 Keith Ave.
Knoxville, TN 37921
Ph (865) 525-4794
Fax (865) 521-5632

**Project Lagniappe** provides services to biological, extended, foster and adoptive families of infants and children, who are HIV infected and/or substance exposed, through a comprehensive coordinated case management and consortia building approach.

**CONTACT:** Children’s Hospital of New Orleans
200 Henry Clay Ave.
New Orleans, LA 70118
Ph (504) 821-4611
Fax (504) 822-2084

**Project Stable Home** provides a full range of in-home and center-based services and case management to preserve the mother-infant dyad on behalf of young children who have been prenatally exposed to alcohol or other drugs or HIV, or who are at high risk for maternal abandonment.

**CONTACT:** Children’s Institute International
21810 Normandie Ave.
Torrance, CA 90502
Ph (310) 783-4677
Fax (310) 783-4676

**Project Protect** is an in-home service program that provides a matrix of permanency planning services and psychosocial, legal and entitlement counseling to help families plan for their children’s future, which is vulnerable due to serious parental illness or substance use.

**CONTACT:** The Family Center
66 Reade St., 4th Floor
New York, NY 10007
Ph (212) 766-4522
Fax (212) 766-1696
www.thefamilycenter.org

**Drug-Exposed Infant Project** assesses the developmental and permanency needs of young children in foster care and works intensively to support and engage the children’s birth and foster families to ensure that each child develops a primary attachment to a consistent caregiver and achieves permanency quickly.

**CONTACT:** Leake and Watts Services, Inc.
1529 Williamsbridge Rd.
Bronx, NY 10461
Ph (718) 794-8314
Fax (718) 794-8201

**CONGRATULATIONS!**

The following fifteen programs were awarded four-year grants from the U.S. Department of Health and Human Services’ Children’s Bureau under the Abandoned Infants Assistance (AIA) legislation.
**Epiphany STAR Project** focuses on early intervention for infants prenatally exposed to drugs by providing therapeutic day care and parenting skills training for mothers attending Epiphany’s outpatient drug treatment program.

**CONTACT:** Mount St. Joseph-St. Elizabeth  
100 Masonic Ave.  
San Francisco, CA  
94118-4494  
Ph (415) 352-4052  
Fax (415) 292-5531

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**Project BABIES** provides immediate shelter and comprehensive on-site support services for at-risk infants and their mothers who are affected by drugs.

**CONTACT:** Protestant Community Centers  
256 North 7th St.  
Newark, NJ 07107  
Ph (973) 481-2855  
Fax (973) 481-1010

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**Epiphany STAR Project** focuses on early intervention for infants prenatally exposed to drugs by providing therapeutic day care and parenting skills training for mothers attending Epiphany’s outpatient drug treatment program.

**CONTACT:** College of Health and Human Sciences, School of Social Work  
1006 Urban Life Center  
Georgia State University  
Atlanta, GA 30303  
Ph (404) 651-2505  
Fax (404) 651-1863

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**Home and Heart** provides center- and home-based therapy for children of parents, who have HIV/AIDS or substance abuse problems, and their guardians.

**CONTACT:** New York Council on Adoptable Children  
589 8th Ave., 15th Floor  
New York, NY 10018  
Ph (212) 714-2788  
Fax (212) 714-2838

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**GRO Project** offers case management, primary health care, legal assistance, support groups, interdisciplinary services, and community awareness and outreach to strengthen families in which grandparents or other relatives are caring for children affected by prenatal substance use or HIV.

**CONTACT:** University of New Mexico Health Sciences Center  
317 Commercial St., NE, Ste. 100  
Albuquerque, NM 87102  
Ph (505) 272-3459  
Fax (505) 272-3461

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**West Virginia Relative Caregivers Project** is a collaborative project of West Virginia University Extension Service, the Department of Health and Human Resources, and Mission West Virginia, a faith-based organization, that seeks to establish and strengthen support groups for relative caregivers in the rural counties of West Virginia.

**CONTACT:** West Virginia University Extension Service, Center for 4-H and Youth, Family and Adult Development  
603 Knapp Hall, P.O. Box 6031 Morgantown, WV 26506-6031  
Ph (304) 293-2694  
Fax (304) 293-7599

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**Yale Support Program for Family Caregivers** provides home and community-based supportive mental health, counseling and case management services for grandparents and other relatives caring for HIV or drug-affected children in order to increase the likelihood of stable, nurturing caregiver relationships for those children.

**CONTACT:** Yale Child Study Center  
P.O. Box 2207900  
New Haven, CT 06520-7900  
Ph (203) 785-4947  
Fax (203) 785-7402

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**Red Ribbon Trails** will address the multifaceted needs of HIV-affected families and children in Illinois for recreation, respite and therapy through annual family summer camp and winter retreats.

**CONTACT:** Families and Children’s AIDS Network  
53 W. Jackson Blvd., Ste. 409  
Chicago, IL 60604  
Ph (312) 786-9255  
Fax (312) 786-9203
welfare workers lack any meaningful training in substance use services. Meaningful training based on a harm reduction model could go a long way in increasing workers’ effectiveness and sense of accomplishment, when success is not measured solely by abstinence, but on well-being for women and their children. Similarly, if harm reduction program staff received training in issues specific to pregnancy and parenting, they could provide immediate information and referrals for pregnant and parenting women who are not receiving health and social services. In any case, a child welfare/substance use dialogue about harm reduction “can focus on the central issue of reducing harm to children while considering the behavior of parents in treatment and in recovery” (Young, Gardner, & Dennis, 1998).

**Conclusion**

Harm reduction seeks ways to allow women to be responsible and act upon their concern for their children, the well-being of their families, their desire for healthy relationships, and their goals for their own lives. Harm reduction provides an opportunity to engage women in a non-punitive, non-condemning way, and it provides a door through which women can safely explore the impact and cost of substance use in their and their children’s lives. Agencies have to be willing to engage women who are pregnant and provide accurate information and, where available, appropriate referrals for their specific needs. However, we must also hold systems and policies of welfare and criminalization accountable for their role in exacerbating the condition of vulnerability for women and their children, and in bringing together the often-polarized agendas of meeting the needs of both women and their children. We must look at the needs of women, their children, and their families, not as opposed to, but as part of the larger goal of family wellness, and we must develop social policies and programs that support all families.

**REFERENCES**


**YES**

effectively care for their children. With these systemic changes and more realistic interventions, we argue that parents will be less likely to engage in activities that create harm for themselves and their children, and better equipped to adequately parent their children.

**Sheila Murphy and Paloma Sales,**

Center for Substance Abuse Studies, Community Health Works, Institute for Scientific Analysis

**REFERENCES**


alone can adversely affect parenting. For example, mothers who are chronically depressed (postpartum depression) have been found to be less sensitive with their infants, feel more overwhelmed with the caring for their children, and are more anxious about their competence as a parent (Campbell, 1992). The behavioral dynamics involved in substance abuse and mental illness may further adversely affect parenting as well as child development (Freier, 1994; Luthar, Cushing, Merikangas, & Rounsaville, 1998). For instance, substance abusing women who have chronic depressive or paranoid symptoms show significantly less sensitive caregiving towards their children than substance abusing women who do not have chronic depression or paranoia (Beckwith, Howard, Espinosa, & Tyler, 1999). For some mothers, these mental health problems abate when they are drug free. However, for others they do not.

Conclusion

Given the addictive lifestyle and the often accompanying psychological problems, active drug users generally are not able to focus on the needs of their children and, therefore, do not provide them with the protection, care and nurturance that they need for healthy development. As long as they are still using, parents’ primary focus is on obtaining drugs rather than caring for their children, regardless of how much they care about their children. At the same time, abstinence alone does not ensure effective parenting. To adequately care for their children, parents must not only abstain from drugs; they must also make behavioral and lifestyle changes and, when necessary, receive services to address any related mental health issues. Abstinence may enable parents to shift their focus to their children and begin to make changes necessary to provide a safe and nurturing environment.

Rachelle Tyler, MD,
Department of Pediatrics, UCLA Medical School

REFERENCES


Promoting Self-Care and Self-Advocacy in Women Impacted by Substance Abuse and Dependency

Thursday, February 21, 2002

Irene Jillson, PhD
Founder and President, Policy Research Incorporated, Bethesda, MD

This presentation will focus on issues that impede or promote self-care in women impacted by chemical addiction. Reasons for lack of self-care and strategies for intervening in a positive and supportive way will be shared. Recovery is presented as a window of opportunity to help empower women to improve their self-care and self-advocacy.

HIV Prevention for Women: The Kitchen Sink Model

Wednesday, March 20, 2002

Annette “Chi” Hughes, MSW Director, Division of Community Health and HIV Services, Prototypes Centers for Innovation in Health, Mental Health, and Social Services, Culver City, CA

The Kitchen Sink Model addresses the multiple factors that place women at risk for HIV infection. By addressing risk factors concomitantly, programs allow clients to design their own intervention(s), prioritize needs, and participate at their own pace. This model engenders a sense of empowerment and self-efficacy in women.

Helping Women Recover: A Comprehensive Integrated Treatment Model

Wednesday, April 17, 2002

Stephanie S. Covington, PhD, LCSW, Co-director, Institute for Relational Development, La Jolla, CA

This teleconference will feature a new model for treating women who are chemically addicted. The Helping Women Recover program is based on the integration of three theories: addiction, women’s psychological development, and trauma. The structure and content of this gender-responsive treatment program will be discussed with a focus on four areas: self, relationship, sexuality, and spirituality. The seminar will also discuss the integration of spirituality and psychotherapy.

Integrating Domestic Abuse and Substance Abuse Services

Tuesday, June 11, 2002

Carey Tradewell Monreal, MS, CADC III,President, Milwaukee Women’s Center, Milwaukee, WI

This teleconference will highlight an innovative program model that addresses the dual existence of domestic abuse and substance abuse in families. Lessons learned, problems encountered, successful programming, and research will be discussed.

TELECONFERENCE REGISTRATION FORM

The registration fee for each of these 90-minute, interactive teleconferences is $25 per phone line (or $75 for the series). To register and receive the toll-free number and information packet, please complete this form and fax it to (510) 643-7019, then mail it with a check (made payable to UC Regents) to the AIA Resource Center, 1950 Addison Street, Suite 104, Berkeley, CA 94704-1182, ATTN: Margot Broaddus.

Please indicate the date(s): ☐ February 21, 2002 ☒ March 20, 2002 ☐ April 17, 2002 ☐ June 11, 2002

Name: __________________________________________________________
Agency: _________________________________________________________
Address: _________________________________________________________
City, State & Zip: __________________________________________________
Phone: _________________________    Fax: ____________________________

For more information on any of these teleconferences, please contact Margot Broaddus at AIA Resource Center (510) 643-7018 margotb@uclink4.berkeley.edu
Addiction Treatment

This book provides the reader with a brief global perspective of different types of addictions, techniques for identifying and assessing the addicted client, and strategies for effective change. The author uses assessment, planning, and intervention summaries to enable the reader to scan for immediate recall and application. Illustrative cases are included throughout. Cost: $34.95.

S. Rasmussen, 2000. 400 pages. Available through Sage Publications, 2455 Teller Road, Thousand Oaks, CA 91320. Ph: (805) 499-9774; Fax: (805) 499-0871; Email: order@sagepub.com.

Narrative Means to Sober Ends: Treating Addiction and Its Aftermath

This book illuminates the devastating power of addiction and describes an array of innovative approaches to facilitating clients’ recovery. The author includes concepts from family therapy, psychodynamic therapy, and addictions counseling. The book includes case histories, letters, and personal accounts. Cost: $32.50.


Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors

This book provides an introduction to the harm reduction model. The author discusses the model’s rationale and examines a range of applications in diverse communities. Insight is also offered into the philosophical and policy related debates surrounding this growing movement. Cost: $40.00.


Practicing Harm Reduction Psychotherapy: An Alternative Approach to Addictions

This book demonstrates that traditional approaches to addictions are inappropriate for many substance users who also have psychological or emotional problems. The author shows how effective therapeutic work can be conducted with individuals who may still be using drugs. This book offers clinical examples and step-by-step guidelines for assessment and treatment. Cost: $32.50.


Harm Reduction: National and International Perspectives

In this book, the authors discuss the philosophical basis and history of harm reduction policies and examine their outcome. They also cover controversial topics related to harm reduction, especially conflicts between the public health system, and a worldwide criminal justice system that further marginalizes drug users. This book includes descriptions of programs all over the world, including the U.S., Canada, Brazil, the Netherlands, and Australia. Cost: $32.95.


No Safe Haven: Children of Substance-Abusing Parents

This report analyzes the impact of substance abuse on child abuse and neglect. The authors illustrate how parental abuse of alcohol and drugs has overwhelmed the nation’s child welfare system and seriously compromised its ability to protect children. Cost: $22.00; free to download from World Wide Web.


Changing Addictive Behavior: Bridging Clinical and Public Health Strategies

This book draws upon cutting-edge theory and research to examine ways that traditional therapeutic treatments can be supplemented by public health interventions that extend the reach and effectiveness of care. The reader is offered a guide to current issues in the changing world of addiction treatment in North America. The book covers such topics as cost-benefit approaches to treatment; brief interventions; and the “stages of change” model. Cost: $42.00.


Continued on page 26 . . .
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Written for policy makers, this publication provides background information on the link between the foster care system and substance abuse and the challenges of ensuring the safety of children when they are returned home. This publication also provides examples of how legislators can initiate statewide planning processes, integrate child welfare and substance abuse treatment services, and fund treatment and supportive services. Cost: $25.00.

S. Christian & K. Edwards, 2000. 41 pages. Available from the National Conference of State Legislators, 1560 Broadway, Suite 700, Denver, CO 80202. Ph: (303) 830-2054; Fax: (303) 863-8003; Email: books@ncsl.org

Substance Abuse Treatment and the Stages of Change

This book delineates the stages of change model, describing specific clinical issues that arise at different points in the recovery process. It also identifies effective interventions for each stage and with different client populations. Cost: $35.00.


Group Treatment for Substance Abuse

This practical manual presents a 29-session treatment program designed to engage, motivate, and stimulate processes of change in clients at all stages of recovery. It includes handouts and exercise forms. Cost: $25.00.


Overcoming Resistance in Cognitive Therapy

This book integrates ideas from a range of psychotherapeutic approaches to present a model for helping clinicians better understand and work with clients who seem unable or unwilling to make needed changes. The author uses clinical illustrations to provide practical strategies and interventions to deal with various types of resistance. Cost: $35.00.


Adoption and Prenatal Alcohol and Drug Exposure: Research, Policy, and Practice

This book is designed to serve as a resource for practitioners, policymakers, and researchers, providing an analysis on a range of issues connected to prenatal alcohol and drug exposure. The authors provide information on the immediate and long term impacts of prenatal substance exposure on children’s health and well-being, remedial effects of a positive postnatal environment, and services and supports to maximize positive outcomes. Cost: $28.95.


Bridging the Gap: Permanency Planning with Drug-Affected Families

This report summarizes the proceedings, recommendations and supporting research from a workday that addressed collaboration opportunities between child welfare and substance abuse treatment services. Cost: $8.00.


Pediatric Disorders of Regulation in Affect and Behavior: A Therapist’s Guide to Assessment and Treatment

This book provides the most recent advances in addressing disorders of self-regulation. The development of self-regulation from infancy through early childhood is presented. Screening and assessment procedures are described in detail to help the reader evaluate self-regulation, attention, sensory processing, and parent-child interactions in infants and children. Cost: $49.95.


Resolving Childhood Trauma: A Long-Term Study of Abuse Survivors

This book studies 51 adult childhood incest survivors. It focuses primarily on developing an understanding of the role of amnesia following the trauma of child sexual abuse. Five successive surveys combine the richness of intensive personal interviews with objective measures of progress. This book sheds light on the complexity of the healing process and the painful but amazing growth of the survivors. Cost: $27.95.


Counseling Survivors of Childhood Sexual Abuse, 2nd Edition

In this book, the author identifies the significant healing processes – such as disclosing the abuse, reinterpreting it from an adult perspective, addressing issues related to the context of the abuse and making desired life changes. Each of these processes is illustrated through the use of carefully chosen case examples. Cost: $24.95.


It Could Happen to Anyone: Why Battered Women Stay, 2nd Edition

This book provides current information about issues related to domestic violence. The authors provide an analysis of the complex factors that make it difficult for women to extricate themselves from violent relationships. They also present an integrated learning theory explanation of the conditioning that culminates in wife abuse, in the resulting state of the victim, and in the decision to stay with the abuser. Cost: $24.95.

Effective Treatments in PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies

This volume brings together leading clinical scientists to offer best practice guidelines for the treatment of PTSD. Approaches covered include acute interventions, cognitive-behavioral therapy, inpatient treatment, psychosocial rehabilitation, hypnosis, marital and family treatment, and creative therapies. Cost: $42.00.


The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment

This book builds a bridge between the practice of traditional verbal trauma therapy and body-oriented therapies. The author presents an integration of the psychophysiology of trauma and the ways in which clinicians may assist trauma survivors to resolve the effects of overwhelming experience on mind and body. Cost: $30.00.


Recreating Brief Therapy: Preferences and Possibilities

This book reconceives brief therapy in light of postmodern and pragmatic thinking. The result is personal consultation, with a focus on conversation and inquiries that gently guide the pursuit of desire. The authors provide examples of ways that both experienced therapists and beginners can put respect and optimism into practice. Cost: $32.00.


Addictions and Trauma Recovery Manual: Healing the Body, Mind, & Spirit

This book presents the Addictions and Trauma Recovery Integration Model, which blends psychoeducation, process, and expressive activities to address key issues related to trauma and addiction. This how-to-manual includes illustrations, handouts, and interventions that can be used with addiction treatment, trauma-focused psychotherapy, or independently. Cost: $25.00.


Journal of Behavioral Health Services and Research

This interdisciplinary and peer-reviewed journal incorporates research and articles from the nation’s leading behavioral health researchers, providing practical applications of the most current research in alcohol, drug abuse, and mental health. Cost: $66.00.

Available from Aspen Publishers, Inc., P.O. Box 911, Frederick, MD 21704. Ph: (800) 638-8437; Fax: (301) 417-7650; http://www.aspenpublishers.com.

Sexual Assault Report

This bimonthly newsletter provides information regarding innovative programs for working with survivors of sexual assault, and key developments in the law, medicine, counseling, prevention and advocacy. Designed to help in identifying, documenting, and prosecuting sexual assault crimes and protecting and supporting sex crime survivors, Sexual Assault Report is written by practicing professionals for practicing professionals utilizing a multi-disciplinary approach. Cost: $152 for annual subscription.

Available from Civic Research Institute, Inc., P.O. Box 585, Kingston, N.J. 08758. Ph: (609) 683-4450; Fax: (609) 683-7291; http://civicersearchstitute.com.

VIDEOS

Hepatitis C: The Silent Epidemic

This video explores every aspect of hepatitis C (HCV) including diagnosis, symptoms, treatment and its side effects, as well as lifestyle issues specific to people in recovery living with HCV. It provides pertinent information through the testimony of a well-known hepatologist and individuals currently living with the virus. Part 1 of the video stresses the importance of getting screened and seeking medical attention; part 2 shows viewers various ways of managing the disease. Cost: $225.00.

©2000. 29 minutes. Produced by the Hazelden Foundation. Available from Hazelden Veden, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. (800) 328-9000. www.hazelden.org

Restless, Irritable & Discontented: The Basics of Relapse Prevention

Primarily designed for people in recovery, this video examines the attitudes and behaviors that warn of relapse. Through personal stories, the viewer learns how to identify and minimize high-risk situations, how to cope with cravings, and the importance of staying connected to the community of other recovering addicts and alcoholics. Cost: $225.00.

©2000. 18 minutes. Produced by the Hazelden Foundation. Available from Hazelden Veden, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. (800) 328-9000. www.hazelden.org

WEB RESOURCES

Alcoholics Anonymous
www.alcoholics-anonymous.org

This website provides basic information about the structure, policies and traditions of AA, an international fellowship of men and women who have drinking problems and want to stop drinking.

Join Together
www.jointogether.org

This project of the Boston University School of Public Health is a national resource for communities working to reduce substance abuse and gun violence. Their website provides national news and resources related to substance abuse prevention and treatment, and drug control policy and practice.

Welfare Information Network
www.welfareinfo.org

This website provides access to more than 400 organizations and 16,000 electronic resources. WIN offers unbiased information for a better understanding of the policy and program issues involved with the design and delivery of services to improve economic self-sufficiency and the well-being of children and families.

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Maternal-State Conflicts: Claims of Fetal Rights & the Wellbeing of Women and Families

This national, multidisciplinary conference will examine the growing trend of “fetal rights” measures around the country. It will explore the implications for women’s reproductive rights, as well as consequences in the areas of medicine, legal practice, civil rights, women’s rights, racial justice, public health and welfare, drug policy reform, child welfare, HIV/AIDS treatment and prevention, labor issues, and economic justice.

DATE: January 25-27, 2002
LOCATION: New York, NY
SPONSOR: NAPW and Mt. Sinai-based Clinical Education Initiative (CEI)
CONTACT: Lynn Paltrow, Executive Director, NAPW, 45 West 10th St., #3F, New York, NY 10011. Ph: (212) 475-4218; Fax: (212) 254-9679; Email: LMPNYC@aol.com
www.advocatesforpregnantwomen.org

Prevent Child Abuse America National Conference

The theme of this conference is Imagine a nation without child abuse: Combining our strengths for prevention. Workshops will be provided in the following areas: management and leadership; capacity building; working with special populations; research and knowledge; unique prevention approaches; and practical applications for direct service staff.

DATE: March 2-5, 2002
LOCATION: Dallas, TX
SPONSOR: Prevent Child Abuse America
CONTACT: Prevent Child Abuse America, Attn: Cynthia Stringfellow, 200 S. Michigan Ave., 17th Floor, Chicago, IL 60604. Ph: (312) 663-3520, x221.

A System of Care for Children’s Mental Health: Expanding the Research Base

This 15th annual research conference brings together researchers, evaluators, administrators, policy makers, advocates, and family members to describe lessons learned and obstacles overcome, and share promising new methods in applied, practical system of care research. It also explores how policy change can be used to strengthen children’s mental health service systems in communities.

DATE: March 3-6, 2002
LOCATION: Tampa, FL
SPONSOR: Research and Training Center for Children’s Mental Health
CONTACT: Research and Training Center, Department of Child & Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3807. Ph: (813) 974-4661; http://rtckids.fmhi.usf.edu

Children 2002: Making Children a National Priority

This annual national conference highlights the policy, practice, and program information needed to work effectively with children, youth and families, and to promote a national agenda in their behalf. It also provides an opportunity to network with a wide variety of professionals, consumers and advocates.

DATE: March 6-8, 2002
LOCATION: Washington, DC
SPONSOR: Child Welfare League of America
CONTACT: CWLA, 440 First St., NW, 3rd Floor, Washington, DC 20001-2085. Ph: (202) 638-4004; Email: children2002@cwla.org.

18th National Symposium on Child Sexual Abuse

This conference will provide current, comprehensive training on child sexual abuse and child maltreatment to supervisors, law enforcement officers, educators, child protection workers, medical professionals, attorneys, therapists, researchers, judges, and juvenile workers. Discussion topics will include sexual abuse prevention, physical abuse, child fatalities, prevention, treatment, investigation, and domestic violence.

DATE: March 19-22, 2002
LOCATION: Huntsville, AL
SPONSOR: National Children’s Advocacy Center
CONTACT: Symposium Registrar, National Children’s Advocacy Center, 200 Westside Square, Suite 700, Huntsville, AL 35801. Ph: (256) 533-0531; Fax: (256) 534-6883; www.niac-hsv.org

Beyond Adherence: Building Partnerships Among Individuals, Clinicians and Systems

This annual meeting of the Society of Behavioral Medicine will include papers, poster presentations, symposia and seminars on the following topics: addictive behaviors, chronic pain, cancer, cardiovascular disease, chronic disease management, health policy, prevention of risk behaviors, AIDS, psychosocial influences on disease and research to practice.

DATE: April 3-6, 2002
LOCATION: Washington, DC
SPONSOR: Society of Behavioral Medicine
CONTACT: SBM, 7600 Terrace Ave., Suite 203, Middleton, WI 53562. Ph: (608) 827-7267; Fax: (608) 831-5485; Email: info@sbmweb.org; www.sbmweb.org.

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5th National Child Welfare Data Conference

This conference brings together a diverse group of professionals to discuss how to make information technology work and how to use data for program improvement.

DATE: April 10-12, 2002
LOCATION: Arlington, VA
SPONSOR: National Resource Center for Information Technology in Child Welfare
CONTACT: CWLA, 440 1st St., NW, 3rd floor, Washington, DC 20001-2085. Ph: (202) 942-0318; Fax: (202) 638-4004; Email: advertising@cwla.org.

9th Biennial National Family Support Conference

The theme of this conference is Family Support: The time has come! Participants will learn about new research, practice strategies, public policy and advocacy efforts related to the family support movement.

DATE: April 22-25, 2002
LOCATION: Chicago, IL
SPONSOR: Family Support America
CONTACT: Family Support America, 20 North Wacker Dr., Suite 1100, Chicago, IL 60606. Ph: (312) 338-0900; Fax: (312) 338-1522; Email: info@familysupportamerica.org; www.familysupportamerica.org

Community-Campus Partnerships for Health 6th Annual Conference

This conference will address issues such as: partnership leadership, governance, assessment, improvement, principles, best practices, sustainability, tools, resources, and outcomes. Participants will include community, civic, government, philanthropic and health delivery organizations; health professional schools; colleges; and universities.

DATE: May 4-7, 2002
LOCATION: Miami, FL
SPONSOR: Community-Campus Partnerships for Health
CONTACT: CCPH, UCSF, Box 1242, San Francisco, CA 94143. Ph: (415) 476-7081; Email: ccp@itsa.ucsf.edu; http://futurehealth.ucsf.edu/ccph/projects.html.

10th Annual National Colloquium on Child Abuse and Neglect

This conference will provide a range of interdisciplinary, skills-based training seminars on all aspects of child maltreatment, providing the latest data in scientific and legal research as well as practice knowledge.

DATE: May 29-June 1, 2002
LOCATION: New Orleans, LA
SPONSOR: American Professional Society on the Abuse of Children
CONTACT: Heather Newton, P.O. Box 26901, CHO 383406, Oklahoma City, OK 73190. Ph: (405) 271-8202; Fax (405) 271-2931; Email: heather-newton@ouhsc.edu; www.apsac.org.

2002 Family Group Decision Making Roundtable

The theme of this annual event is Revolutionizing practice with children and families: Sustaining and growing the FGDM movement. Families, practitioners, policymakers, administrators, researchers, and juvenile and family court professionals will have an opportunity to engage in thought-provoking, planful discussions about the implementation of FGDM and help to develop local, state and national strategies to maintain and bolster FGDM practice.

DATE: June 2-5, 2002
LOCATION: Monterey, CA
SPONSOR: National Center on Family Group Decision Making
CONTACT: 2002 FGDM Roundtable, c/o Ann Movelz, American Humane Association, 63 Inverness Drive East, Englewood, CO 80112-5117. Ph: (303) 925-9421; Email: ann@americanhumane.org

14th International Congress on Child Abuse and Neglect

This congress will look at past and future international efforts to combat child abuse and neglect.

DATE: July 7-10, 2002
LOCATION: Denver, CO
SPONSOR: International Society for the Prevention of Child Abuse and Neglect, the Kempe Children’s Foundation, and the Kempe Children’s Center
CONTACT: Kempe Children’s Center, 2002 Congress, 1825 Marion St., Denver, CO 80218. Fax (303) 315-8002; Email: 2002@kempecenter.org; www.kempecenter.org.

2002 Training Institutes

These institutes will focus on developing local systems of care for children and adolescents with emotional disturbances and their families. They will address both public policy and clinical practice, reflecting the importance and interdependence of both; and they will include a special emphasis on family involvement and cultural competence in systems of care.

DATE: July 10-14, 2002
LOCATION: Washington, DC
SPONSOR: National Technical Assistance Center for Children’s Mental Health; Child, Adolescent and Family Branch of the federal Center for Mental Health Services; and SAMHSA
CONTACT: NTACCMH, Georgetown University Child Development Center, 3307 M St., NW, Suite 401, Washington, DC 20007-3935. Ph: (202) 687-5000; Fax: (202) 687-1954; Email: institutes2002@mindspring.com.

Rediscovering the Other America: A National Forum on Poverty and Inequality

This national forum will include a keynote by Frances Fox Piven, as well as paper presentations, interactive workshops, and a panel discussion of national policies and practices about poverty and inequality.

DATE: August 18, 2002
LOCATION: Chicago, IL
CONTACT: Keith Kilty, College of Social Work, Ohio State university, 2947 College Rd., Columbus, OH 43210; Ph: (614) 292-7181; Email: Kilty.1@osu.edu
Name _____________________________________________________
Affiliation __________________________________________________
Address ____________________________________________________
City, State, Zip ______________________________________________
Phone _____________________________________________________

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<td>(Video 2000)</td>
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<td>Annual Report on Shared Family Care: Progress and Lessons Learned (2001)</td>
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